Health Information Technology Policy Committee
Summary of the December 15, 2009, Meeting

KEY TOPICS

1. Call to Order
Judy Sparrow, Office of the National Coordinator (ONC), welcomed Health Information Technology (HIT) Policy Committee members and reminded the group that this was a Federal Advisory Committee meeting and thus was being conducted in public.

2. Opening Remarks
HIT Policy Committee Chair David Blumenthal, National Coordinator for Health Information Technology, also welcomed Committee members. He noted that this was a meeting during which the Committee would begin to look ahead to the first calendar year quarter of 2010 and consider what happens after the meaningful use and interim final rules are released.

3. Review of the Agenda
Committee Vice Chair Paul Tang added that the meeting would be largely informational. Once the interim final rules are issued, intense work will follow. Christine Bechtel provided some changes to the minutes from the last HIT Policy Committee meeting (held on October 27, 2009) to Judy Sparrow.

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4. Briefing on the Office of the National Coordinator (ONC) Agenda
David Blumenthal presented a series of slides illustrating American Recovery and Reinvestment Act (ARRA) enabling structures, outlining a series of goals that have been cited in conversations about the purposes of the ARRA Health Information Technology for Economic and Clinical Health Act (HITECH) programs, and the purpose of meaningful use. These include improved clinical and population health outcomes, increased efficiency, empowerment of patients, and the creation of a learning health care system. The belief is that the actual day-to-day implementation of HIT will support all these health care goals. The question is how to get to meaningful use. Widespread adoption of electronic health records (EHRs) is needed, as is the subsequent exchange of EHR data and the enhanced used of that information for patient management and learning purposes. Preconditions such as pathways for exchange and trusted/effective EHRs will be required.

This is the point at which some of ONC's programs come into play (i.e., a series of programs that are not as much about technology as they are about changing the health care system around technology so that there is demand for it and so that it can be used effectively). In terms of supporting the adoption of technology, the ONC is creating a certification process for EHRs. The Office is naming standards that can be built into the data storage and use of those records,

and that will offer assurance that such records are capable of being private and secure. The ONC is establishing a method for the evaluation of efforts to accomplish the adoption of EHRs, so that successes and failures can be tracked. ONC also is supporting research and development to contribute to the improvement of EHRs.

ONC's Regional Extension Center programs are intended to promote adoption and improve trust in EHRs by offering advice to providers on how to pick records systems that are appropriate to their needs. With regard to exchange, the ONC administers state health information exchange (HIE) grants, which are intended to draw states into the business of creating exchanges within their borders. The ONC also hopes to support infrastructure—the development of the Nationwide Health Information Network (NHIN) is critical to effective information exchange, as are privacy and security measures, the coordination of programs and policies within the federal government, and research and development.

The ONC has changed with regard to its mandate and structure. In February of 2009, it was given a mandate to lead the adoption of HIE and provided with the infrastructure necessary to work to achieve meaningful use with the Centers for Medicare & Medicaid Services (CMS). The office now must ensure the adoption of EHRs by 2014, build a nationwide interoperable health care system, and lay the foundation for a learning health care system that can make health care reform a sustainable reality.

To achieve all of these goals, ONC staffing has increased. The ONC now includes the following Offices:
- Office of the Chief Scientist, representing an understanding that this work is at the border of science and practice.
- Deputy National Coordinator (NC) for Operations, overseeing offices of Communication, Mission Support, Strategic Initiatives, Grants Management, and Oversight.
- Office of Communication, which recognizes that the ONC must find a way to make itself understood, especially in light of the new federal regulations coming out shortly.
- Office of the Chief Privacy Security Officer.
- Deputy NC for Programs and Policy, which will oversee the offices of Policy and Planning, Standards and Interoperability, Provider Adoption Support, and State and Community Programs.
- Office of Economic Modeling and Analysis.

In the last eight months, the ONC has been working on three major regulations: (1) meaningful use, (2) EHR standards and certification criteria, and (3) the certification process. The ONC is currently working on more than a dozen new programs, including the Regional Extension Center Program to support HIE and adoption, Health Information Exchanges, Workforce Training, and Beacon Communities. These various programs fit together into an emerging framework for IT adoption. David Blumenthal presented a theoretical state with regional extension centers, community college programs, and Beacon Communities, with some of these programs being housed within others in some cases, and standing alone in other cases. The hope is that the lessons learned from the Beacon Communities will inform the curricula of community colleges and workforce training programs, and that all of these will be supported by infrastructures that states create to promote exchange. All of these programs should be working together.

In discussion, the following points were made:

- The NHIN represents an effort to create a resource readily available and usable for all providers who want to exchange information with one another. It is a set of protocols and standards and practices that, if followed, will permit exchange of information conveniently and easily, using such existing technology as the Internet. It is not an attempt to create a new, separate way of exchanging information, but a way of facilitating exchange. The Veterans Administration (VA), Department of Defense (DoD), and the Social Security Administration (SSA) have already worked for a number of years along with Kaiser and a few other groups to build this network. This Committee now has a workgroup in place to consider what the next steps should be with regard to the NHIN.
- The Beacon Community program was announced on December 2, 2009. It is a pilot program to push the state-of-the-art technology to a new level. Fifteen diverse communities around the country, already well underway in terms of adoption, have been invited to come forward for their share of $225 million to look at HIT resources to improve efficiency within their respective communities during a 36-month period.
- David Blumenthal explained that states are going to have varying roles, and the ONC does not yet know what all of those will be. They have been given a lot of discretion to come forward with their own plans, and the ONC has not processed those plans completely. States must carry out a number of critical activities—for example, directories of licensed professionals and organizations that are appropriate to receive and send private/secure health information are needed and it is the states that license these entities. Also, states collect public health information; making sure they are part of an exchange capability is critical. In some cases, states have been leaders in creating HIEs within their boundaries. States collect Medicaid data, and the ONC wants them to make that available for exchange. It is hoped that states will take advantage of the NHIN, and that they will help put together patterns of exchange that will help guide the ONC.
- LaTanya Sweeney suggested that, in the revised organizational chart for the Office of the National Coordinator, there ought to be an Office of Health Information Technology.

5. Meaningful Use Workgroup Update

Meaningful Use Workgroup Co-Chair George Hricpsak presented the Workgroup's timeline, including an informational hearing on patient and family engagement. This upcoming discussion will focus on sharing data, disseminating knowledge, and making decisions. At the hearing, Meaningful Use Workgroup members will consider the future of information-enabled patients and family engagement, how to measure success, and policy barriers and enablers.

6. Certification/Adoption Workgroup Update

Certification/Adoption Workgroup Co-Chair Paul Egerman reminded the Committee that in August, the Workgroup offered recommendations concerning certification. Since then, the Certification/Adoption Workgroup has been awaiting completion of the funding process and the various ONC components presented earlier in the meeting by David Blumenthal.

On the certification side, Workgroup members were concerned that there was only one certifying organization—the Certification Commission for Healthcare Information Technology (CCHIT)—the Workgroup wanted to allow for multiple certifying agencies. The Drummond Group has

surfaced as additional certifying organization; it has taken the Workgroup's recommendations and are proceeding under the assumption that they will be accepted in the final rulemaking process. The Drummond Group's work will emphasize vendors that provide products for small physician groups.

Paul Egerman said they will be watching to see how the software vendors are reacting. Vendors who sell to acute care institutions are reporting brisk demand in the second half of the year. He speculated that there is enough known about the process that groups are buying systems because they feel they need to get started. He added that the Committee should view this positively and as an indicator that it has had a fairly dramatic impact on the industry. The challenge, after the software is produced and certified, will be workforce training and reaching meaningful use. It is hoped that the Workgroup will collaborate with the ONC to develop some metrics for measuring adoption. In fact, the name of the Workgroup is being changed to the Adoption and Certification Workgroup.

The points were raised during the discussion that followed:
- One Committee member asked if there is a process in place to monitor what groups are adopting, and if that adoption is rolling across safety net providers. Such a process is necessary to ensure that disparities in access to HIT are not increasing. Paul Egerman commented that this issue has not been raised in previous Workgroup discussions, but will be brought to the table for consideration.
- David Blumenthal noted that prior to his appointment as National Coordinator, the ONC created a monitoring system that has produced a fair amount of information on this topic. It is run through two large national surveys, and in both cases one can look at safety net providers defined in a variety of ways, and try to distinguish who is adopting and at what level of functionality. The hope is to continue and augment those programs.

7. Information Exchange Workgroup Update and Recommendations
Information Exchange Workgroup Co-Chair Micky Tripathi shared the group's recommendations on standardizing electronic laboratory transactions. There are numerous ways in which lab transactions occur today, both on the ordering and the receiving side—most are not electronic. There are a variety of business, technical, and regulatory issues that create barriers to progress towards standardization and few incentives or requirements for those receiving or producing labs. The Health Information Technology for Economic and Clinical Health (HITECH) Act changes the landscape somewhat, but nevertheless there is relatively little training on either side regarding how to accommodate electronic ordering or results. Also, there is no built-in way to monitor and enforce electronic lab transactions today, because everything is decentralized.

There are a variety of policy levers available, including HITECH as well as meaningful use, certification, standards, and the support that comes from HIE and Regional Extension Center funds. Other levers that the workgroup identified include government contracts and the Clinical Laboratory Improvement Amendments (CLIA). The Information Exchange Workgroup's recommendations focus on three critical issues/questions: (1) which vocabulary and messaging standards should be required (the Standards Committee approved standards in September, but

stakeholders do not appear to have heard about them); (2) how will these standards be monitored and enforced; and (3) how can it be ensured that patients get prompt access to lab results?

Micky Tripathi explained that the Standards Committee recommended the HITSP-approved Standards Implementation Guide for lab results delivery, and they approved Logical Observation Identifiers Names and Codes (LOINC) as a vocabulary standard. They also allowed a temporary exception for HL7 interfaces, which this Workgroup disagrees with. Instead, they believe the exception should not be adopted now, but a glidepath for enforcement of the standards should be set to fall into place by 2013. They recognized the issue and the reason for naming the exception, but they think their proposal makes a stronger statement.

In discussion, the following points were made:
- Deven McGraw noted that it is disturbing that not a single presenter at their recent panel acknowledged the standards work that has already been done by the HIT Standards Committee.
- Tony Trenkle suggested that the ONC and CMS carefully consider a timeline for adoption of standards—Micky Tripathi noted that a number of CMS staff have been working closely with the Workgroup on this matter.
- Roger Baker asked if there is funding available for the lab side of adoption, as there is funding for the EHR side of adoption, under the meaningful use incentive. There do not appear to be such incentives. If they can agree to a standard, his belief is that the market will enforce certification, and that it may not be necessary for the government to issue a certification component. Micky Tripathi indicated that this type of demand pull-through has not yet taken place. Many providers do not have the option of choosing which labs to work with, because insurers often require the use of a particular lab.
- LaTanya Sweeney noted that one of the concerns could be that if a provider's systems support standardized methods but also other methods for lab, there will be no incentive to use proper lab protocol. Without that limitation, the provider could have the ability to receive standard lab protocol, but not use it.
- Paul Egerman suggested that there is too much flexibility in the current specifications, so each group is implementing in a slightly different manner. This variability should be removed. Meaningful use will not succeed without interoperability, and the same applies to lab results. He emphasized that lab results must be included in EHRs.
- Jodi Daniel noted that a National Governors Association analysis on CLIA will be finalized and available soon.
- Christine Bechtel voiced disappointment that there are no recommendations regarding patient access to lab data. She asked the Workgroup to consider the following:
  - Meaningful use requirements around timely access to lab data should be strengthened.
  - ONC should look to Kaiser, which provides real-time access for patients to lab data, at the same time as physician access. Analyze what the privacy and security implications are for consumers, and how that information is aggregated and used.
  - CMS should consider the implications of changing CLIA so that patients are named as a designated recipient of lab results.
- LaTanya Sweeney noted that there is an economic advantage for large labs to use a proprietary system. What is the mechanism for pushing a change? She proposed that, for

meaningful use, the measure should be, not "how many labs are being reported electronically?" but "how many are being reported electronically using the standards?"

- Gayle Harrell reminded the Committee that issues involving consumer access would require statutory changes, because states already have regulations dealing with patient access.
- David Blumenthal suggested that two recommendations be accepted today, with the others being tabled until the next meeting so that the various agencies, stakeholders, and lawyers can study them further.

> **Action Item #2:** The Committee accepted two of the workgroup's recommendations, listed below. The other recommendations will be discussed again at the next Policy Committee meeting. Accepted recommendations:
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> - ONC should require national standards for messaging, vocabulary, and measure codes, and create means for widespread availability of authorized implementation guides and code-sets.
> - The CMS CLIA Office should issue a survey and certification letter for laboratories that would include: (1) interpretive guidance for presentation of lab information in user-facing applications (EHRs, HIEs, and PHRs); (2) interpretive guidance for interfacing reflecting the messaging and vocabulary standards set forth above; and (3) best practices reinforcing the above guidance.
>   - The sending of results using these messaging and vocabulary standards should be deemed acceptable for meeting the criteria of presentation of lab results in user facing applications.
>   - This survey and certification letter should deem EHR certification as demonstration of adherence to the guidance, which should eliminate the need for labs to test each EHR implementation.

8. NHIN Workgroup: Membership, Scope

NHIN Workgroup Chair David Lansky explained that this new Workgroup has had one meeting to date and has identified a set of meaningful use criteria from the matrix that seem to require information exchange. From there, the group examined pushing data from an EHR or other system to another known user. This is a very focused subset of tasks involved in the overall agenda; Workgroup members are considering those areas in which data are pushed from one provider to another. The following considerations are relevant for these transactions: foundational NHIN components, vocabulary standards, document/messaging standards, directories and certificates, delivery protocols, authentication, and security. Of these, directories and certificates represent an area with problems that are fairly easily remedied. On December 15, 2009, the Workgroup is convening a hearing to focus on directory functionality. In January, the Workgroup will hold a hearing on authenticating information that is being set

Farzad Mostashari discussed key issues associated with exchanging patient data, including the following key considerations: (1) reinforcing a solid trust, (2) determining how to achieve authentication, (3) identifying what can be done to achieve the use of information exchange, (4) clarifying the role of government, and (5) enabling broad participation. One Committee member noted that as the NHIN Workgroup clarifies the role of government, it would also be helpful to

clarify whether the government is the owner/operator in perpetuity of the exchange network and whether it is free to anyone who chooses to use it.

9. Privacy and Security Policy Workgroup: Membership, Scope
Privacy and Security Policy Workgroup Chair Deven McGraw shared the membership list and charge of the new Workgroup, which has had one meeting to date. She noted that the National Center for Vital and Health Statistics (NCVHS) has done some recent work on some of the issues the Workgroup hopes to tackle—she and Co-Chair Rachel Block have scheduled a call with that organization's two privacy Co-Chairs to leverage the synergy between these two entities (it is also hoped to leverage work of the NHIN and other relevant workgroups as well).

David Blumenthal suggested that they work with Judy Sparrow and Jodi Daniel to introduce recommendations in tranches, so that the committee has enough time to discuss them fully.

10. Strategic Plan Workgroup: Membership, Scope
Strategic Plan Workgroup Chair Paul Tang explained that updating the ONC's strategic plan is mandated by statute, and that Strategic Plan Workgroup members include representatives from both the HIT Policy and HIT Standards Committees. The Workgroup's broad charge is to advise the National Coordinator on strategic policy framework issues.

Workgroup Co-Chair Jodi Daniel explained that the Workgroup intends to update the strategic plan y in collaboration with federal partners and stakeholders. A draft of the framework paper is expected by March 2010; a listening session to obtain broader public input is planned for April. Following that session, a version of the plan will be brought before the full Policy Committee. The goal is to push the plan through the clearance process and have it published in final form by the end of October 2010. The Strategic Plan Workgroup is focusing on four overarching themes: (1) promoting meaningful use of HIT, (2) leveraging information and technology to support a learning health care system, (3) establishing privacy and security policies supporting public trust and participation in HIT, and (4) establishing policies for technical infrastructure supporting electronic health information capture and exchange.

11. Panel on Health Plans
Paul Tang introduced Charles Kennedy, who moderated the panel on health plans. Charles Kennedy presented a series of slides to introduce the discussion, and explained that one frequently asked question is: why haven't payers invested in health care technology? He pointed to a disconnect between the amount of money that this technology is supposed to save, and the amount that it actually saves. In addition, the deployment of technology has typically been more focused on the operation within the institution than on the care of a patient.

Andrew Wiesenthal, Kaiser Permanente
Kaiser Permanente is the largest private integrated health care delivery system in the United States and is different than many other payers in that it is a delivery system with the insurance/payer function built in. In 2003, Kaiser Permanente Health Connect was deployed—it is now the sole medical record for Kaiser's 8.6 million members, and it is the system that employees now use every day. Andrew Wiesenthal commented that Kaiser's members generally are better at being the organizing hub of their care than are providers. The Health Connect

system has allowed practitioners to develop evidence-based treatment plans, and he said they expect to dramatically increase the safety of care as well as its efficacy.

The goal of electronic health care systems should be to improve the quality of care, and to provide feedback to the provider or group of providers to develop meaningful assessments of quality. Performance measurement is challenging, and few organizations have the capacity to do it. Collectively, however, the U.S. health community has the skills and resources to overcome this obstacle.

Julie Klapstein, Availity
Availity is a health information exchange, not a payer. It connects more than 150 health plans directly, and even more indirectly, to doctor's offices. It provides administrative, financial, and clinical transactions between health plans, clinicians, and hospitals. Administrative and financial transactions paid for by the health plans cover the company's costs of doing business. Providers do not pay for the service. All hospitals and 95% of physicians' offices in Florida use Availity's portal and clearinghouse to exchange information with health plans and each other. Availity Care now has an electronic medical record to augment its EHRs. The system is valuable because it is current, includes patient-provided information, and allows providers to note what happened to the patient in other care settings.

Julie Klapstein explained that the infrastructure being built from the clinical side does not have to be set up from scratch, because the existing administrative network used today for claims transactions can be used for clinical exchange as well. The new standards that are being developed now will be used in the construction of such a network. Availity uses ICD-9/10, and encodes all the data it can, such as lab results. It is using the CCR protocol today, but is ready to use CCA as well. Availity uses single factor authentication today, but is considering 2-factor authentication for the future. It is important to make sure that whatever is specified is usable by the normal physician, or no one will adopt. For encryption, the organization uses HTTPS and VPN via the Internet. Provider data management is a challenge; in the future, a centralized directory will be beneficial.

Julie Klapstein stressed the importance of building a sustainable business model. Availity does not charge payers or providers—the financial and administrative charges cover all costs. In concluding her remarks, she urged the importance of scalability for the systems to be developed.

Andrew Slavitt, Ingenix
Ingenix is a health information technology consulting company with more than 10,000 team members in 50 countries. Ingenix has a longitudinal database covering 90 million patients that spans 15 years. Over past decade, the company has developed perspectives on how HIT can support physicians at the point of care. Current challenges are unlikely to be solved with financial incentives alone. Andrew Slavitt cited two concerns that need to be addressed: (1) many doctors believe that introducing EHRs will introduce significant new costs, and (2) many believe that EHRs will make care more complicated, not better

Andrew Slavitt offered an example of how the State of Michigan used technology to improve care and save money. During one flu season, whenever a Michigan child on Medicaid went in

for a doctor's visit, a notification occurred on the child's EHR indicating that the doctor should give them a flu vaccine. Under this program, 59,000 children were treated, and the state saved an estimated $200 million in health care costs.

Physicians need help managing their patients and managing their overburdened offices. Solving these problems is a key to getting widespread adoption of technology. He said that information cannot simply be dumped from the payer to the provider's office; a good portal is needed. Also, workflow solutions cannot cost tens of thousands of dollars up front and require constant upgrades and training. Office technology should be seen as an access point to a great web of information. Ingenix Care Tracker is one product that acts as such an access point. Andrew Slavitt noted that his written testimony to the Committee also includes some specific policy considerations.

Catherine MacLean, WellPoint
Catherine MacLean pointed out that administrative and clinical data sets are complimentary and when linked, provide more useful information than either data set alone. This stems from the fact that each data set fills in gaps inherent in the other. Hundreds of measures are currently being used at WellPoint, and she still sees huge data gaps. But even so, the data are valuable because they already exist, and there is no burden of data collection for small providers. The most meaningful measures are outcome measures, such as morbidity, health status, and pain levels. Most meaningful clinical measures cannot be applied to administrative data.

Rick Miller, Wellmark Blue Cross and Blue Shield
Rick Miller indicated that the panel thus far had included a great deal of information on how programs work operationally. His interest lies in how to work with clinicians to make this happen—it is a cultural challenge as much as it is an operational one. In all areas of the health care system, the same barriers of quality improvement exist. It is hard to create a good business case for providers for quality improvement. Pay for performance is not a new concept; a system already exists that basically rewards productivity in terms of number of clinic visits, exams, etc. Rewards come in the form of fees. This creates much more hospital and clinic access than there was previously, but there is no incentive for quality and coordination of care.

In Iowa and South Dakota, Wellmark wanted to create a system to incent and reward providers to provide higher quality care, and one in which providers felt ownership. The focus of that activity was to create a business case for quality. A better, more efficient way to collect data was needed—Wellmark created an online registry for practitioners. They needed to have standard measures, and used NQF. They used diabetes, hypertension, and cancer screening as examples.

Outcomes improved from 35% to 73% on average. Rick Miller commented that providers generally do a good job for the patients in front of them—the ones that do not come in are the ones that bring the numbers down. A patient registry allows for tracking of patients and gives practitioners a mechanism to prompt them to come in, or take whatever action is necessary. Clinic visits and drug utilization increased, and emergency room/hospital visits are decreasing. There has been a large difference observed with the clinics that use the data meaningfully by entering it regularly, looking at it, doing outreach, employing health coaches, etc., compared

with those that do not. Their outcomes are significantly better than the ones that have not made the leap to using the data that they collect.

Discussion
The discussion that followed included the following points:
- Charles Kennedy noted that many of the initiatives and programs carried out by large providers can be applied to the small practices.
- It was noted that if doctors are given the right environment and tools, they will figure out how to achieve the goals that have been set out. The tools needed are IT at the point of care that does not carry with it extra work for the physician. Incentives for the health teams that physicians work with, not just physicians themselves, are needed.
- One panelist cautioned against creating more payment structures that reward getting to a means rather than getting to an end. Instead, it was suggested that this Committee and all of the experts focused on this issue should create reliable information that will help incent primary care physicians to get and keep people healthy.
- Andrew Wiesenthal said that all the members of a health team must be given a specific challenge. "Every eligible woman must have a mammogram," for example. Explicit transformational care targets are needed. He said that people tend to do all the old things using the new technology. They must be told, do this in a different way.
- Andrew Wiesenthal commented that explicit transformational care targets are needed. Providing patients with access to their doctors, labs, and other medical information has resulted in a significant change. Kaiser doctors, just like any other doctors, did not like the idea of doing quality improvement, releasing data to patients, or opening their schedules up to the public—now that they have had to, however, the system is effective and the physicians are happier for it.
- Andrew Slavitt explained that Ingenix's research database is depersonalized and walled off. The information has come from a lot of different clients over many years, with their permission. He said that there must be firm, uniform, consistent rules about privacy, and that there should not be frequent rule changes. Also, he proposed putting in place rigorous certification of privacy programs to establish good practices, and adding pure health data research under the Health Insurance Portability and Accountability Act (HIPAA).
- Andrew Wiesenthal commented that major IT projects should be led by clinicians rather than IT professionals, because this is a cultural change more than a technological problem. They need to own the remaking of their own environment, and lead the change, rather than being the victim of an "IT coup." These clinicians would get some training in IT, but mostly the training necessary would be in the management of projects. He proposed that extension centers could play this role, providing leadership training for physicians and community leaders. He explained that less than one-third of Kaiser's implementation budget was for software licensure; more than half of it was for training, change management, and the loss of productivity while change happens.
- One panelist noted that the uncoordinated incentives that are being presented physicians do not solve the many administrative processes they face. It was suggested that excessive processes be removed by providing technology that would help them streamline these processes.

12. Briefing from the HIT Standards Committee

Dixie Baker offered an update from the Standards Committee's Privacy and Security Workgroup. She presented a series of slides to clarify the privacy and security standards recommendations for 2011. The slides included all of the Privacy and Security Workgroup's proposed standards—which are intended for use in certifying EHR products—based on HIPAA and ARRA requirements, and supporting standards.

Then, she reported on the security hearing that the Workgroup held on November 19. The hearing included four panels: (1) systems stability and reliability; (2) cybersecurity; (3) data theft, loss, misuse; and (4) building trust. Throughout all four of the panels, building trust was an overarching theme. Some of the key messages from this hearing that are relevant for the Policy Committee include the following:
- Security awareness is extremely low and many organizations even now do not comply with HIPAA.
- One-half of the organizations polled in a recent, major study indicated that they have no security personnel on staff.
- One-half of the organizations polled spent 3% or less of their budget on information security.

Implementation Workgroup Chair Aneesh Chopra updated the Policy Committee on the Implementation Workgroup's recent activities. To address concerns related to being centered mostly in Washington, DC, and not gathering enough "on-the-ground" information, the Workgroup engaged a broader set of voices during the month of November. Their objectives were to understand what the adoption experience so far and bring to the surface any barriers for opportunities so that course corrections can be made moving towards 2011, 2013, and 2015. The Implementation Workgroup was interested in learning about how adoption can be accelerated, how as many providers as possible can be made ready to do data exchange as quickly as possible, and how a feedback loop can be put into place. In addition to a live hearing, the Workgroup held an online forum that lasted for 3 weeks following the day of the hearing. The online forum allowed individuals to react to specific topics, and provided the American people with an opportunity to present comments and also vote on them. Findings from this hearing were presented at the last Standards Committee meeting.

From all of this input, the Implementation Workgroup developed the following top 10 themes that will serve as guiding principles moving forward:
1. Keep it simple
2. Don't let perfect be the enemy of good enough
3. Keep the implementation cost as low as possible
4. Design for the "little guy"
5. Do not try to create a one-size-fits-all standard
6. Separate the content and transmission standards
7. Create publicly available vocabularies and code sets
8. Leverage the Web for transport
9. Position quality measures so they motivate standards adoption
10. Support implementers.

In conclusion, Aneesh Chopra reported that the Workgroup learned that there is substantial concern about state of EHRs. They must think big, start small, and move fast; and they must

separate content from transport. Also, they need to combine the best of Internet and informatics thinking. The question they took away from the hearing is, do they need complex solutions to answer complex questions?

John Halamka suggested that the Implementation Workgroup must: (1) work on vocabularies; (2) consider adding a REST-based transport method; (3) work jointly with the HIT Policy Committee to establish a primary framework; (4) use the fewest, simplest standards possible; and (5) continue to gather feedback.

Dixie Baker and LaTanya Sweeney agreed to talk offline about concerns that LaTanya Sweeney has about what she characterized as "a serious orthogonal mismatch" in the Privacy and Security Workgroup's recommendations.

One Committee member urged group not to ignore lessons learned by early adopters. The experiences and successes of early adopters could be considered as possible *de facto* early standards.

13. Public Comment
Bob Hall from the American Academy of Pediatrics commented that children are repeatedly forgotten in many of the systems that are being set up. He also noted that Medicaid is going to become the backbone of the U.S. medical system, and pointed out that incentives are very different in Medicaid than in Medicare. Only about one-half of the pediatric practices are going to receive the incentives because of the way they are structured. Also, as a field, pediatrics uses very different data. The minute of birth is important, as are growth charts. Including these would be helpful. Regarding immunization registries, screening test data are important. The Children's Health Insurance Program Reauthorization Act includes a specific child-specific EHR format that he is hoping can be plugged into the discussion moving forward.

Corinne Rubin from the American Academy of Ophthalmology discussed lab requirements for meaningful use. She noted that ophthalmologists typically do not order enough tests for labs to make much use of that functionality within EHRs, she said. She also emphasized that that physicians must feel like they are involved in the setting standards.

Michael McGraff from the Smart Card Alliance Healthcare Council discussed trust issues as they relate to the NHIN and authentication. He explained that although Level 2 assurance provides some confidence, Level 4 is most appropriate for very high confidence.

SUMMARY OF ACTION ITEMS

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  - The sending of results using these messaging and vocabulary standards should be deemed acceptable for meeting the criteria of presentation of lab results in user facing applications.
  - This survey and certification letter should deem EHR certification as demonstration of adherence to the guidance, which should eliminate the need for labs to test each EHR implementation.